STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G496	A. BUILDING 00 B. WING	10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	2333 WESTDALE CT KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for an extended recertification and state licensure survey. Dates of Survey: 10/13, 10/14, 10/15, 10/16, 10/19, 10/20, 10/26, and 10/27/2015. Facility Number: 001010 Provider Number: 15G496 AIM Number: 100245040 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/9/15.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, for 2 of 4 sampled clients (clients #2 and #4) and 2 additional clients (clients #6 and #8), the governing body failed to exercise operating direction over the facility to ensure their bedroom closets had doors/closures for clients #2, #4, #6, and #8. Findings include:	W 0104	**CorrectiveAction(s):** **Toensure that the governing body will exercise general policy, budget, andoperating direction over the facility by adding doors/closures on clients #2,#4, #6, and #8's bedroom closets, the following corrective actions will beimplemented and followed:** 1.Residential House manager will getdoors/closures for clients	11/26/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	During observations on 10/13/15 from 3:45pm until 6:05pm and on 10/14/15 from 6:35am until 8:15am, clients #4, #6, #2, and #8's (shared) bedroom closet doors/closures were missing. On 10/13/15 at 5:20pm, GHS (Group Home Staff) #3 indicated she was unsure how long clients #2, #4, #6, and #8's closet doors/closures were missing. On 10/14/15 at 6:55am, GHS #2 indicated she was unsure how long clients #2, #4, #6, and #8's closet doors/closures had been missing. On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated she was not aware clients #2, #4, #6, and #8's bedroom closets did not have a closure to the doorway. The DRS indicated no further information was available for review. 9-3-1(a)		#2, #4, #6, and #8's bedroom closets and BonaVista's maintenance department will hang the doors/closures. 2.Residential House manager will do aweekly safety check to ensure that all bedroom closets have doors/closures onthem. (Appendix A)	
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.			

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	Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to ensure unimpeded access to the locked toothbrushes, toothpaste, deodorant, shampoo, and liquid soap for clients #1, #2, #3, #4, #5, #6, #7, and #8 who did not have documented assessments for the restricted access to the locked items. Findings include: During observations on 10/13/15 from 3:45pm until 6:05pm and on 10/14/15 from 6:35am until 8:15am, clients #1, #2, #3, #4, #5, #6, #7, and #8 walked throughout the facility. The medication room door was kept locked when staff was not inside the room. During both observation periods clients #1, #2, #3, #4, #5, #6, #7, and #8 had to request a toothbrush, toothpaste, deodorant, shampoo, and liquid shower soap from the facility staff. On 10/13/15 at 4:03pm, client #3 walked into the medication room and asked GHS (Group Home Staff) #1 for shampoo for a shower and liquid shower soap. GHS #1 unlocked a file cabinet inside the locked secured medication room, removed two bottles, one bottle of shower gel, and one bottle of shampoo. GHS #1 squeezed out 30cc	W 0125	**CorrectiveAction(s):** **To ensure all clients have unimpeded access topersonal items such as toothpaste, deodorant, shampoo, ect the followingcorrective measures will be implemented:** 1.Allclients that reside in the group home will be provided with their own personalshower boxes where they have access to their own personal toothbrushes,toothpaste, deodorant, shampoo, and liquid soap. The Residential HouseManager will train all staff working in the home on client rights regardingaccess to and the use of personal hygiene items. Additionally, all staff willbe trained on the use of shower boxes for each client. (Appendix B and AppendixC) Records of training will be completed following staff trainings andsubmitted to the Residential Director for administrative oversight	11/26/2015

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	of each liquid into a calibrated medication cup and handed the cups to client #3. At 4:28pm, GHS #1 stated clients #1, #2, #3, #4, #5, #6, #7, and #8's toothbrushes, toothpaste, deodorants, shampoo, and liquid bathing soaps were "kept locked up in the office" and did not recall the reason. GHS #1 indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 did not have keys to the secured items. On 10/14/15 at 8:00am, clients #1, #2, #3, #4, #5, #6, #7, and #8 indicated they did not have keys to the medication room and had to ask staff for the use of the locked personal care items. On 10/15/15 at 3:10pm, client #1's record was reviewed. Client #1's 12/21/14 ISP (Individual Support Plan) and 2014 Risk Assessment did not indicate an identified need to lock personal items such as toothbrushes, toothpastes, deodorants, shampoos, and liquid bathing soaps. Client #1's record did not indicate consent for locked items. On 10/15/15 at 10:59am, client #2's record was reviewed. Client #2's 6/7/2015 ISP, 6/7/2015 BSP (Behavior Support Plan), and 2015 Risk Assessment did not indicate an identified need to lock personal items such as toothbrushes, toothpastes, deodorants, shampoos, and liquid bathing soaps.			

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	Client #2's record did not indicate consent for locked items. On 10/15/15 at 1:00pm, client #3's record was reviewed. Client #3's 6/7/15 ISP, 8/2015 BSP, and 2015 Risk Assessment did not indicate an identified need to lock personal items such as toothbrushes, toothpastes, deodorants, shampoos, and liquid bathing soaps. Client #3's record did not indicate consent for locked items. On 10/15/15 at 3:16pm, client #4's record was reviewed. Client #4's 1/21/15 ISP, 8/2015 BSP, and 2014 Risk Assessment did not indicate an identified need to lock personal items such as toothbrushes, toothpastes, deodorants, shampoos, and liquid bathing soaps. Client #4's record did not indicate consent for locked items. On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated she was not aware clients #1, #2, #3, #4, #5, #6, #7, and #8's shampoos, deodorants, liquid bathing soaps, toothbrushes, and toothpastes were kept secured. The DRS indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had not given consent for the locked items. The DRS indicated no assessments were completed for clients #1, #2, #3, #4, #5, #6, #7, and #8. No reason was provided			

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	of why locked personal care items were kept locked inside the medication room. The DRS indicated no other information was available for review regarding the locked items. 9-3-2(a)			
W 0129 Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #2 and #4) and 2 additional clients (clients #6 and #7), the facility failed to keep client #2, #4, #6, and #7's personal information confidential by posting each client's full names, work locations, group home addresses, and workshop schedules. Findings include: On 10/14/15 from 9:45am until 11:20am, clients #2, #4, #6, and #7 were observed at the facility owned day services. Visitors, other clients, family members, vendors, and workshop staff were observed to enter and exit the workshop area. At 10:40am, a posted sheet of paper included a list of clients #2, #4, #6,	W 0129	**CorrectiveAction(s):** **Thefacility must ensure the rights of all clients. Therefore, the facility mustprovide each client with the opportunity for personal privacy. The following correctivemeasures will be implemented:** 1.Allconfidential information has been removed from documentation that can be seenby others at the Bona Vista workshop. All clients will be addressed on anydocumentation that is in view of others by their HIPPA names. Work locations,group home addresses, and work schedules will not be placed in public view andwill be kept confidential.	11/26/2015

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	and #7's names who attended workshop. The sheet of paper indicated a 10/14/15 "Sign In / Sign Out Sheet" which indicated clients #2, #4, #6, and #7's full names, each client's group home address, the area of the workshop in which each client worked, and if the client was leaving the workshop area. At 10:50am, the Workshop Supervisor (WKS) was interviewed and indicated clients #2, #4, #6, and #7's personal information was not kept confidential when the information was posted on a reception table at the entrance/exit accessible to vendors, visitors, other clients, other staff, and families. On 10/16/15 at 2:45pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated clients #2, #4, #6, and #7's personal information with their individual names should not have been posted at the facility entry/exit in full view of people leaving and entering the workshop. The DRS indicated the group home staff failed to keep client #2, #4, #6, and #7's personal information confidential. 9-3-2(a)			
W 0149	483.420(d)(1)			

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Bldg. 00	STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 4 of 6 substantiated allegations of staff to client abuse, neglect, and/or mistreatment for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8), the facility neglected to ensure clients #1, #2, #3, #4, #5, #6, #7, and #8 were not subjected to staff to client abuse, neglect, and/or mistreatment. Based on record review and interview, the facility neglected to implement the agency's policy and procedure to immediately report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law and to ensure sharps were kept secured for clients #6 and #7. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and for 4 additional clients (clients #5, #6, #7, and #8), the facility failed to complete effective corrective action to address the continued client to client physical aggression for clients #1, #2, #3, #4, #5, #6, #7, and #8 for 25 of 82 reportable incidents reviewed.	W 0149	**Finding(s):** **1.*"Thefacility neglected to ensure all clients that reside in the group home were notsubjected to staff to client abuse, neglect, and/or mistreatment."*** **CorrectiveAction(s):** **Toensure to implement and follow written policies and procedures that prohibitmistreatment, neglect, or abuse of the client the following corrective actionwill be taken:** 1.ResidentialHouse manager will retrain all staff working in the home on Bona Vista's Policyand Procedure for abuse, neglect, and exploitation. Records of training will be completedfollowing all trainings and be submitted to the Residential Director for administrativeoversight. (appendix D) 2.ResidentialQualified Intellectual Disabilities Professional (QIDP) will retrain all thestaff working in the home on BDDS reportable incidents and Bona Vista's Policyand Procedure for reporting incidents. Records of training will be completedfollowing the training and be submitted to the Residential Director for administrativeoversight. (appendix E)	11/26/2015

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	Findings include: 1. On 10/14/15 at 12:40pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents of substantiated staff to client allegations of abuse, neglect, and/or mistreatment: -A 6/30/15 BDDS report for an incident on 6/30/15 at 8:00am indicated the group home staff left the group home "around 8:00am to take and drop off [clients #1, #2, #3, #4, #5, #6, #7, and #8] at [the name of workshop] for day services." The report indicated the staff returned to the group home at "approximately 8:30am," unlocked the front door, medication cabinet doors were open, a window in the office was opened, and the clients' medication boxes and clients' money boxes were gone. The report indicated the agency credit cards were gone and a police report was filed. Staff were suspended pending an investigation. The report indicated "all" client medications and money will be replaced by the agency and all doors and window locks were changed by the agency maintenance. The 6/30/15 "Police Report" indicated the break in occurred while the night shift		3.TheResidential Social Service Coordinator will conduct an investigation for allallegations of abuse, exploitation, and/or mistreatment. An incident reportthrough the Bureau Developmental Disabilities will be filed for all incidentsor allegations of abuse, neglect, exploitation, and/or mistreatment. Achecklist is attached to each completed investigation to ensure completion ofall required processes and forms. (Appendix F) The completed investigation will be reviewed by the Residential Directorand the Executive Vice President to ensure all investigations are thoroughlycompleted, recommendation/corrective actions are included, and an incidentreport has been filed. **Finding(s):** *1.“**Thefacility neglected to implement the agency’s policy and procedure toimmediately report allegations of staff to client abuse, neglect, and/ormistreatment to the administrator and to the Bureau of DevelopmentalDisabilities Services (BDDS) in accordance with State Law and to ensure sharpswere kept secured for clients #6 and #7.”*** **CorrectiveAction(s):** **Toensure that all sharps are**	

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	staff and the day shift staff had transported clients to the workshop. The "(office) window in the back of house (sic) was point of entry. Office door was still locked and window was unlocked and person was able to open window to entry and exit. Money box was taken with $232.23. Drug box was taken with 7 types of medication in it...Officer [name] stated he believes it was an inside job...." A 7/8/15 "Memo: Termination/Talking Memo" indicated for Discharged Staff #22: indicated "the home was burglarized on 6/30/15 when drugs, money, credit cards were stolen from the home." The Memo indicated "You being one of two staff on shift at the time of the incident, you were suspended pending an investigation. In compliance with federal and state regulations and for promotion of a drug free Indiana (sic). [Name of Agency] has a strong commitment to providing a safe, alcohol, and drug free workplace. Unlawful manufacturing, selling, distribution, dispensing, possession, or use of a controlled substance or a prescription medication for which an employee doesn't hold a valid prescription, as well as consumption of alcohol beverages, is prohibited...On 7/2/15 you were given a drug test...in correlation with the investigation process...On 7/7/15 we		**kept in a secured place for clients #6 and #7 thefollowing corrective actions will be implemented:** 1.ResidentialQualified Intellectual Disabilities Professional (QIDP) will retrain all thestaff working in the home on clients #6 AND #7's Behavior Support Plans (BSP's)and Human Right Committee (HRC) approved restrictions for client #6 and #7. Recordsof training will be completed following the trainings and submitted to theResidential Director for administrative oversight. (Appendix G)	

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	received the results of your drug test. You tested positive in three different categories Marijuana, Oxycodone, and Oxymorphone." Discharged Staff #22's employment was terminated on 7/8/15. -A 3/12/15 BDDS report for an incident on 3/10/15 at 8:00am indicated "It was reported that midnight [Name of Staff] had woke (sic) [client #7] up at night and was upset with him for putting dirty clothes in with the clean clothes (in his bedroom). [Client #7] became verbally aggressive towards the staff. It was reported that [name of staff] told [client #7] she was not scared of him and if he tried to hit her she would take his arm behind his back so quick and take him down." The report indicated client #7 went back to bed. The incident was not reported until 3/12/15 to the administrator. -A 3/12/15 BDDS report for an incident on 3/10/15 at 8:00am, indicated "It was reported that midnight [Name of Staff] had given [client #1] a bracelet as a reward and [name of staff] had threatened to take (it) back if [client #1] displayed any behaviors." The report indicated staff was suspended. The incident was not reported until 3/12/15 to the administrator.			

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	-A 3/12/15 BDDS report for an incident on 3/10/15 at 8:00am, indicated "It was reported that midnight [Name of staff] had [client #3] get on the floor in the bathroom and clean up his urine off the floor when he missed the toilet. It was also reported that [name of staff] requires [client #3] to say yes ma'em (sic) prior to her giving him something he wants." The report indicated staff was suspended. The incident was not reported until 3/12/15 to the administrator. -The 3/12/15 Investigation indicated the allegation was "Substantiated" and Discharged Staff #22 went to the DRS (Director of Residential Services) "with a complaint of another staff member working in the same home....reports that [name of midnight staff] was throwing some of the consumers things in the trash...heard [name of midnight staff] yelling at [client #3]...saw [client #3] on his hands and knees cleaning the urine off of the bathroom floor with no gloves on. He stated that [name of midnight staff] said that [client #3] was going to learn to not urinate on the floor, or he was going to sit on the toilet like a woman...She admitted that she made [client #3] clean up his urine off the floor and did not wear gloves...." The investigation indicated the midnight staff admitted to confronting client #7			

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	regarding his co-mingling of dirty and clean clothing inside his bedroom. The investigation indicated the midnight staff "admitted to" telling clients #1, #2, #3, #4, #5, #6, #7, and #8 "they have to call her ma'am...out of respect." The investigation indicated the midnight staff "admitted" that she "had given the girls in the home bracelets and told them that if they did not behave or they didn't call her ma'am then she was taking the bracelets back." The investigation indicated clients #3 and #7 were "scared" of the midnight staff name. The investigation indicated staff written witness statements from Discharged staff #22, GHS (Group Home Staff) #2, and GHS #6 which recalled each allegation of staff abuse and/or mistreatment for clients #1, #3, and #7. The Investigation did not address why the allegations were not immediately reported to a supervisor, did not address the midnight staff continuing to work in the group home after the events, and did not give times/dates for clients #1, #3, and #7's allegations. No evidence was available for review regarding if the allegations were immediately reported. -An 4/23/15 BDDS report for an incident on 4/21/15 at 7:30pm indicated client #1 reported that GHS #7, "team lead, had put his hand down his (own) pants on 4/21/15 while [the clients living at the			

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	15G496	A. BUILDING 00 B. WING	10/27/2015

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	group home] were watching television. [Client #1] stated that [GHS #7's] hand was only there for a few seconds but it made her feel uncomfortable." The report indicated client #7 was in the same room "and also witnessed [GHS #7's] hand in his pants as well." The report indicated GHS #7 was suspended pending an investigation. The report indicated "the initial investigation shows that [GHS #7] had an itch and had scratched right below his waist while watching television." The incident was not reported to the administrator. -The 4/22/15 investigation indicated GHS #7's witness statement "...(I) wasn't paying attention. Scratched myself and was sitting next to [client #7] and I forgot he's uncomfortable with it...In pants or outside of pants? Kind of inside. Who was present? There were consumers in room. (I) didn't think anyone was watching. I didn't do it to be socially inappropriate. During med (medication) pass [client #1] told [GHS #1] and said [client #1] was upset...[GHS #1] said she was going to report [GHS #7]. (I) said okay and called [the Residential Manager] right away." The 4/22/15 investigation indicated the allegation was "Partially Substantiated." The investigation indicated GHS #7			

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	"stands too close to staff and consumers (clients) at times...likes to give the consumers and staff frequent hugs." The investigation "Recommendations" indicated "During the course of the investigation it has been determined that [GHS #7] has failed to complete job duties as assigned therefore manager staff is recommending termination." The investigation included an 4/28/15 "Termination/Talking Memo" which indicated "on April 21, 2015 you were observed touching your genitals in the presence of consumers, which caused the consumers to experience emotional distress and humiliation...during the course of the investigation it could not be determined if you were touching yourself inappropriately or just scratching yourself as you had stated when questioned...however, through the course of the investigation it has been determined that you do not complete job duties as assigned and do not assist or perform the daily tasks required...The APS (Adult Protective Services) investigator reviewed the documentation as well and agreed with the agency's findings. Your failure to provide a safe environment for all persons served is in direct violation." The investigation did not address why the incident was not reported to the administrator.			

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	-An 4/10/15 BDDS report for an incident on 4/10/15 at 1:30pm indicated client #6 was on break at workshop, client #6 left the break area, and left the workshop through the outside door. Staff in the area did not follow client #6 and left the area to locate client #6's regular staff in a different area of the building. Client #6 was located walking outside the main workshop and returned to the workshop with staff. The report indicated the staff was suspended and "retrained" on client #6's BSP (Behavior Support Plan) to follow client #6 when he left AWOL (Absent without Leave). The Report and investigation both indicated the staff neglected to implement client #6's BSP to ensure client #6's safety. 2. On 10/14/15 at 12:40pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents of substantiated staff to client allegations of abuse, neglect, and/or mistreatment: -An 4/28/15 BDDS report for an incident on 4/28/15 at 7:30am indicated client #7 "kicked" client #8, "shoved" client #6, "ran to kitchen and grabbed a knife," threatened others with the knife, and staff used physical interventions to remove the			

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	knife from client #7's hands. During observation on 10/13/15 from 3:45pm until 6:05pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home. At 4:00pm, GHS #1 administered medications and on the shelf inside the medication room was a locked box containing locked/secured sharps of knives, forks, can opener, apple coring utensil, razors, and other metal sharp objects. At 4:20pm, GHS #1 retrieved a knife GHS #3 requested. GHS #1 stated the locked sharps were "because of" client #7's behaviors and the facility staff had to "keep sharps locked." At 5:00pm, client #6 was in the kitchen cutting tomatoes with a knife, GHS #4 took the knife from client #6, and finished cutting the tomatoes. At 5:00pm, GHS #4 began to cut lettuce with the knife, GHS #4's personal cell phone in her pocket began to ring, GHS #4 laid the knife down on the counter, walked into the medication room talking on her cell phone. The knife was left unsecured on the counter. At 5:40pm, client #7 walked into the kitchen to wash his hands at the kitchen sink. At 5:50pm, clients #1, #2, #4, #5, #6, #7, and #8 were seated at the dining room table. Two (2) knives laid unsecured on top of the kitchen counter.			

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	On 10/14/15 from 9:45am until 11:20am, observation was conducted at the facility owned day services. During the observation period client #7 sat in a classroom with six other clients and one workshop staff and a pair of unsecured metal scissors laid on the table. On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS stated client #7 "required locked sharps" to be secured. On 10/19/15 at 10:45am, client #6's record was reviewed. Client #6's 7/25/15 ISP and 7/25/15 BSP indicated he needed locked and secured sharps "at all times." Client #6's plans indicated he required 24/7 (twenty-four hours a day/seven days a week) staff supervision. On 10/19/15 at 10:30am, client #7's record was reviewed. Client #7's 5/16/15 ISP and 9/25/15 BSP indicated client #7 "required" locked sharps due to prior attempts of hurting other people with knives during waking and sleeping hours. Client #7's plans indicated he required 24/7 (twenty-four hours a day/seven days a week) staff supervision. On 10/16/15 at 2:45pm, an interview was conducted with the Director of			

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	Residential Services (DRS). The DRS indicated clients #6 and #7 needed secured locked knives and sharps. The DRS indicated both clients #6 and #7 had a documented behavioral history that sharps should be kept secured and locked "at all times except" when staff were directly supervising the use. 3. On 10/14/15 at 12:40pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents of client to client physical aggression: For client #2: -A 5/7/15 BDDS report for an incident on 5/6/15 at 10:45am indicated client #2 was hit by another unidentified client at the workshop on her shoulder. -An 4/13/15 BDDS report for an incident on 4/12/15 at 5:40pm indicated client #2 had purchased a new item, client #4 "wanted [client #2's] item," client #2 refused to give her item to client #4, and client #4 hit client #2 on the arm. For client #3: -An 8/16/15 BDDS report for an incident on 8/15/15 at 12:55pm indicated clients #3 and #6 were carrying in groceries when client #3 "shoved" client #6			

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	through the front doorway which caused client #6 to fall scraping his right knee and a small bruise. -A 6/15/15 BDDS report for an incident on 6/14/15 at 6:00pm indicated client #2 "walked through the doorway" and client #3 "pushed her." No injury was noted. -A 6/5/15 BDDS report for an incident on 6/4/15 at 1:00pm indicated client #3 "came up from behind a female" at workshop and "was inappropriate" wrapping his arms around the person. -An 4/13/15 BDDS report for an incident on 4/12/15 at 6:00pm indicated client #3 was in the kitchen for a drink, asked client #5 twice to move so he could get a spoon, client #5 did not move "fast enough," and client #3 "hit her in the stomach." For client #4: -An 10/7/15 BDDS report for an incident on 10/6/15 at 6:45pm indicated client #2 "reported" that client #4 "punched her on the left shoulder." No injuries were noted. -An 4/30/15 BDDS report for an incident on 4/30/15 at 9:00am indicated client #4 "tried to hug the agency nurse," client #4 was redirected from hugging, and client			

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	#7 shoved client #4 away from the nurse. -An 4/28/15 BDDS report for an incident on 4/28/15 at 6:00pm indicated client #7 was "mad, yelling, ran, then kicked" client #4 in the right hip while he was eating at the table. Client #4 had a "light red" area on his buttocks. -An 4/5/15 BDDS report for an incident on 4/5/15 at 8:00pm indicated client #8 was "crying and said" client #4 "hit her on left side." No injury noted. For client #7: -A 9/8/15 BDDS report for an incident on 9/7/15 at 6:20pm indicated client #7 was watching television and kicked client #6 in "both legs." No injury. -A 9/8/15 BDDS report for an incident on 9/7/15 at 6:00pm indicated client #7 was "agitated" and kicked client #8 in her left lower leg. -An 8/6/15 BDDS report for an incident on 8/5/15 at 5:45pm indicated client #7 had "increased behaviors" at workshop, client #7 called police expressing suicidal threats, police responded, client #7 ran away from police, client #7 was handcuffed, and taken to the local hospital.			

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	-An 8/5/15 BDDS report for an incident on 8/4/15 at 3:30pm indicated client #7 "yelled, kicked, and scratched" client #2 in the left (L) leg while watching television (TV). -A 8/5/15 BDDS report for an incident on 8/4/15 at 4:00pm indicated client #7 was "agitated," told client #8 to "be quiet," "kicked" client #2 in the left leg, and "hit" client #4 in the head. -A 5/27/15 BDDS report for an incident on 5/27/15 at 8:00am indicated client #7 was "upset all day...targeted housemates, hit [client #3] on right arm, kicked [client #8] in the leg, and later in the day [client #7] made scratches on his stomach with a spoon." The report indicated client #7 was taken to the hospital by the Residential Manager and he punched her windshield in the car. -A 5/25/15 BDDS report for an incident on 5/24/15 at 2:00pm indicated client #7 was "agitated" and hit client #6 on the right knee. -A 5/23/15 BDDS report for an incident on 5/23/15 at 2:45pm indicated client #7 was "yelling" and sitting on the sofa, client #7 "kicked" client #8's left lower leg.			

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	-A 5/12/15 BDDS report for an incident on 5/11/15 at 8:20pm indicated client #7 was "punching self in the kitchen, banging hands and head," called client #4 "names," and client #4 hit client #7 on the top of his head. Client #7 had a bruised right arm. -A 5/12/15 BDDS report for an incident on 5/11/15 at 1:58pm indicated client #7 was "arguing" with client #8, kicked client #8 in the shin, hit client #8 in the stomach, and "sat" on client #8. -An 4/28/15 BDDS report for an incident on 4/28/15 at 7:30am indicated client #7 "kicked" client #8, "shoved" client #6, "ran to kitchen and grabbed a knife," threatened others with the knife, and staff used physical interventions to remove the knife from client #7's hands. -An 4/28/15 BDDS report for an incident on 4/27/15 at 4:30pm indicated client #7 kicked client #8, client #7 "tried" to apologize, client #8 refused client #7's apology, and client #7 grabbed client #8's right arm and kicked her. No injuries were noted. -An 4/10/15 BDDS report for an incident on 4/10/15 at 7:50am indicated client #7 was eating in the kitchen, became "mad and hit" client #5 in the left shoulder and			

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	"shoved" client #5 "twice into the wall." The report indicated client #5 had "red marks" on her shoulder. -An 4/4/15 BDDS report for an incident on 4/4/15 at 5:15pm indicated client #7 "talked" with client #4, client #4 kicked client #7 in the left leg. No injuries noted. For client #8: -An 4/13/15 BDDS report for an incident on 4/13/15 at 8:30am indicated clients were "arguing" at workshop about a "job," client #8 was hit by the other client with an open hand on the right arm. No injuries were noted. On 10/16/15 at 2:45pm and on 10/19/15 at 4:00pm, interviews were conducted with the DRS (Director of Residential Services). The DRS indicated no corrective measures were documented and none were available for review after clients #1, #2, #3, #4, #5, #6, #7, and #8 continued to be involved in client to client physical aggression. The DRS indicated the facility followed the BDDS policy and procedure for allegations of abuse, neglect, and/or mistreatment. The DRS indicated the facility did not immediately report to the administrator and/or to BDDS in accordance with State Law and did not investigate client #1 and			

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	#6's allegation regarding GHS #7 and for clients #1, #2, #3, #4, #5, #6, #7, and #8's allegations regarding staff neglect and/or mistreatment. On 10/16/15 at 1:00pm, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...." On 10/16/15 at 1:00pm, a record review of the facility's undated policy and procedures for Abuse, Neglect, Exploitation indicated "Abuse, Neglect, Exploitation" neglect was defined as "failure to provide goods and/or services			

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	necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment...." The policy indicated failure to implement clients' program plans could also be considered neglect. The policy indicated the facility staff should immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS in accordance with State Law. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and for 4 additional clients (clients #5, #6, #7, and #8), the facility failed to complete effective corrective action to address the continued client to client physical aggression for clients #1, #2, #3, #4, #5, #6, #7, and #8 for 25 of 82 reportable incidents reviewed. Findings include:	W 0157	**CorrectiveAction(s): Toensure when an alleged violation is verified that appropriate corrective actionis taken the following will be implemented and followed:** 1.TheSocial Service Coordinator completes all investigations of client to clientaggression. When an alleged violation is verified the Social ServiceCoordinator will contact the Residential Qualified Intellectual DisabilitiesProfessional (QIDP)	11/26/2015

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	During observation on 10/13/15 from 3:45pm until 6:05pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home. At 4:00pm, GHS #1 administered medications and on the shelf inside the medication room was a locked box containing locked/secured sharps of knives, forks, can opener, apple coring utensil, razors, and other metal sharp objects. At 4:20pm, GHS #1 retrieved a knife GHS #3 requested. GHS #1 stated the locked sharps were "because of" client #7's behaviors and the facility staff had to "keep sharps locked." At 5:00pm, client #6 was in the kitchen cutting tomatoes with a knife, GHS #4 took the knife from client #6, and finished cutting the tomatoes. At 5:00pm, GHS #4 began to cut lettuce with the knife, GHS #4's personal cell phone in her pocket began to ring, GHS #4 laid the knife down on the counter, walked into the medication room talking on her cell phone. The knife was left unsecured on the counter. At 5:40pm, client #7 walked into the kitchen to wash his hands at the kitchen sink. At 5:50pm, clients #1, #2, #4, #5, #6, #7, and #8 were seated at the dining room table. Two (2) knives laid unsecured on top of the kitchen counter. On 10/14/15 from 9:45am until 11:20am,		and submit corrective action for the violation. TheResidential Director and the Executive Vice President reviews all completedinvestigations and will ensure that appropriate corrective action has beensubmitted for additional administrative oversight.	

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	15G496	A. BUILDING 00 B. WING	10/27/2015

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	observation was conducted at the facility owned day services. During the observation period client #7 sat in a classroom with six other clients and one workshop staff and a pair of unsecured metal scissors laid on the table. On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS stated client #7 "required locked sharps" to be secured. On 10/19/15 at 10:45am, client #6's record was reviewed. Client #6's 7/25/15 ISP and 7/25/15 BSP indicated he needed locked and secured sharps "at all times." Client #6's plans indicated he required 24/7 (twenty-four hours a day/seven days a week) staff supervision. On 10/19/15 at 10:30am, client #7's record was reviewed. Client #7's 5/16/15 ISP and 9/25/15 BSP indicated client #7 "required" locked sharps due to prior attempts of hurting other people with knives during waking and sleeping hours. Client #7's plans indicated he required 24/7 (twenty-four hours a day/seven days a week) staff supervision. On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS			

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	indicated clients #6 and #7 needed secured locked knives and sharps. The DRS indicated both clients #6 and #7 had a documented behavioral history that sharps should be kept secured and locked "at all times except" when staff were directly supervising the use. On 10/14/15 at 12:40pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents of client to client physical aggression: For client #2: -A 5/7/15 BDDS report for an incident on 5/6/15 at 10:45am, indicated client #2 was hit by another unidentified client at the workshop on her shoulder. -An 4/13/15 BDDS report for an incident on 4/12/15 at 5:40pm indicated client #2 had purchased a new item, client #4 "wanted [client #2's] item," client #2 refused to give her item to client #4, and client #4 hit client #2 on the arm. For client #3: -An 8/16/15 BDDS report for an incident on 8/15/15 at 12:55pm indicated clients #3 and #6 were carrying in groceries when client #3 "shoved" client #6 through the front doorway which caused			

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	client #6 to fall scraping his right knee and a small bruise. -A 6/15/15 BDDS report for an incident on 6/14/15 at 6:00pm indicated client #2 "walked through the doorway" and client #3 "pushed her." No injury was noted. -A 6/5/15 BDDS report for an incident on 6/4/15 at 1:00pm indicated client #3 "came up from behind a female" at workshop and "was inappropriate" wrapping his arms around the person. -An 4/13/15 BDDS report for an incident on 4/12/15 at 6:00pm indicated client #3 was in the kitchen for a drink, asked client #5 twice to move so he could get a spoon, client #5 did not move "fast enough," and client #3 "hit her in the stomach." For client #4: -An 10/7/15 BDDS report for an incident on 10/6/15 at 6:45pm indicated client #2 "reported" that client #4 "punched her on the left shoulder." No injuries were noted. -An 4/30/15 BDDS report for an incident on 4/30/15 at 9:00am indicated client #4 "tried to hug the agency nurse," client #4 was redirected from hugging, and client #7 shoved client #4 away from the nurse.			

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	-An 4/28/15 BDDS report for an incident on 4/28/15 at 6:00pm indicated client #7 was "mad, yelling, ran, then kicked" client #4 in the right hip while he was eating at the table. Client #4 had a "light red" area on his buttocks. -An 4/5/15 BDDS report for an incident on 4/5/15 at 8:00pm indicated client #8 was "crying and said" client #4 "hit her on left side." No injury noted. For client #7: -A 9/8/15 BDDS report for an incident on 9/7/15 at 6:20pm indicated client #7 was watching television and kicked client #6 in "both legs." No injury. -A 9/8/15 BDDS report for an incident on 9/7/15 at 6:00pm indicated client #7 was "agitated" and kicked client #8 in her left lower leg. -An 8/6/15 BDDS report for an incident on 8/5/15 at 5:45pm indicated client #7 had "increased behaviors" at workshop, client #7 called police expressing suicidal threats, police responded, client #7 ran away from police, client #7 was handcuffed, and taken to the local hospital. -An 8/5/15 BDDS report for an incident			

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	on 8/4/15 at 3:30pm indicated client #7 "yelled, kicked, and scratched" client #2 in the left (L) leg while watching television (TV). -An 8/5/15 BDDS report for an incident on 8/4/15 at 4:00pm indicated client #7 was "agitated," told client #8 to "be quiet," "kicked" client #2 in the left leg, and "hit" client #4 in the head. -A 5/27/15 BDDS report for an incident on 5/27/15 at 8:00am indicated client #7 was "upset all day...targeted housemates, hit [client #3] on right arm, kicked [client #8] in the leg, and later in the day [client #7] made scratches on his stomach with a spoon." The report indicated client #7 was taken to the hospital by the Residential Manager and he punched her windshield in the car. -A 5/25/15 BDDS report for an incident on 5/24/15 at 2:00pm indicated client #7 was "agitated" and hit client #6 on the right knee. -A 5/23/15 BDDS report for an incident on 5/23/15 at 2:45pm indicated client #7 was "yelling" and sitting on the sofa, client #7 "kicked" client #8's left lower leg. -A 5/12/15 BDDS report for an incident			

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	on 5/11/15 at 8:20pm indicated client #7 was "punching self in the kitchen, banging hands and head," called client #4 "names," and client #4 hit client #7 on the top of his head. Client #7 had a bruised right arm. -A 5/12/15 BDDS report for an incident on 5/11/15 at 1:58pm indicated client #7 was "arguing" with client #8, kicked client #8 in the shin, hit client #8 in the stomach, and "sat" on client #8. -An 4/28/15 BDDS report for an incident on 4/28/15 at 7:30am indicated client #7 "kicked" client #8, "shoved" client #6, "ran to kitchen and grabbed a knife," threatened others with the knife, and staff used physical interventions to remove the knife from client #7's hands. -An 4/28/15 BDDS report for an incident on 4/27/15 at 4:30pm indicated client #7 kicked client #8, client #7 "tried" to apologize, client #8 refused client #7's apology, and client #7 grabbed client #8's right arm and kicked her. No injuries were noted. -An 4/10/15 BDDS report for an incident on 4/10/15 at 7:50am indicated client #7 was eating in the kitchen, became "mad and hit" client #5 in the left shoulder and "shoved" client #5 "twice into the wall."			

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	The report indicated client #5 had "red marks" on her shoulder. -An 4/4/15 BDDS report for an incident on 4/4/15 at 5:15pm indicated client #7 "talked" with client #4, client #4 kicked client #7 in the left leg. No injuries noted. For client #8: -An 4/13/15 BDDS report for an incident on 4/13/15 at 8:30am indicated clients were "arguing" at workshop about a "job," client #8 was hit by the other client with an open hand on the right arm. No injuries were noted. On 10/16/15 at 2:45pm and on 10/19/15 at 4:00pm, interviews were conducted with the DRS (Director of Residential Services). The DRS indicated no corrective measures were documented and/or available for review after clients #1, #2, #3, #4, #5, #6, #7, and #8 continued to be involved in client to client physical aggression. 9-3-2(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active			

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	treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to implement clients #1, #2, #3, #4, #5, #6, #7, and #8's ISPs (Individual Support Plans) and BSPs (Behavior Support Plans), failed to implement ISP objectives, and failed to allow clients to demonstrate their skills when opportunities existed. Findings include: 1. During observation on 10/13/15 from 3:45pm until 6:05pm, clients #1, #2, #3, and #6 were at the group home. From 4:30pm until 4:55pm, client #1 (without a helmet) and client #6 wore a helmet and rode their individual three wheel bicycles separated by the distance of a city block, while GHS (Group Home Staff) #1 watched from across the road on the sidewalk while walking with clients #2 and #3 up and down the sidewalk. Clients #1 and #6 rode down the middle of the street and turned their three wheel bicycles around by turning on the blacktop and into the lanes of oncoming traffic. One end of the road was a dead	W 0249	**CorrectiveAction(s): Toensure that all clients receive continuous active treatment programmingconsistent of needed interventions and services in sufficient number andfrequency to support the achievement of the objectives identified in the individualprogram plan, the following corrective actions will be implemented andfollowed:** 1.TheResidential Qualified Intellectual Disability Professional (QIDP) willimplement Bicycle safety risk plans for Client #1 and client #6 and willinclude safety equipment required to wear and steps to follow for monitoring.Pedestrian safety checklist will be revised for client #1 and #6. InformalBicycle Safety program goals will be added for client #1 and client #6. TheResidential QIDP will train all staff that work in the home on all plans whenrevised. All records of training will be completed following the trainings andbe submitted to the Residential Director for administrative oversight. (AppendixH) 2.TheResidential QIDP will re-train all staff that work in the group home on all 8client's ISP's, BSP's, all Human Right	11/26/2015

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	end and the other end of the road merged with a main road for the city. During the observation period trucks and cars were observed entering and exiting the road. No redirection was observed. GHS #1 walked holding onto client #2's hand and while talking with client #3. GHS #1 stopped walking in front of the group home driveway, while clients #1 and #6 remained riding their bicycles a city block to 1 1/2 blocks away. During observation on 10/13/15 at 5:50pm, clients #1, #2, #4, #5, #6, #7, and #8 were speaking verbally and sat down at the dining room table for supper. From 5:50pm until 6:05pm, GHS #3, GHS #4, and GHS #5 began to serve clients #1, #2, #4, #5, #6, #7, and #8 their supper meal. GHS #3 stood by the prefilled covered serving bowls and serving dishes which she placed on the dining room table. GHS #3 uncovered one bowl at a time and GHS #3 passed the bowl to each client seated around the table. Client #8 refused to have a bun on her plate. GHS #3 stated "You must have a bun." Client #8 refused the bun three more times. GHS #3 picked up a bun from the bag of buns she was holding, made a quick movement towards client #8's plate, client #8 grabbed GHS #3's wrist, and pushed GHS #3's hand and bun away. Client #8 stated loudly "I ain't		Committee (HRC) approved restrictionsfor the entire home, and Individual program goals. All records of trainingswill be completed following the trainings and submitted to the ResidentialDirector for administrative oversight. (Appendix I) 3.TheResidential House manager will train all staff that work in the home on clientRights (offering choices and supporting independence). All records of trainingswill be completed following trainings and submitted to the Residential Directorfor administrative oversight. (Appendix J) **W249 Finding(s):** ***1."Toprotect resident privacy and confidentiality."*** **CorrectiveAction(s): Toensure onsite monitoring will be done to protect resident privacy andconfidentiality.** **1.The Vice President and the Directorof Bona Vista's Day Service Programs will do a weekly check of the Sky programclassrooms to ensure that all confidential resident information is protectedand not in sight. Any breech of protected information that is found will bereported immediately to the Residential Director and a meeting will be held todiscuss further resolutions to protect the resident's confidential	

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	taking no bun." GHS #3 spoke loudly and over the dining room table to GHS #4 and GHS #5 regarding clients #1, #2, #4, #5, #6, #7, and #8's food, which clients got each amount of food, and staff did not speak to clients #1, #2, #4, #5, #6, #7, and #8. GHS #3 stated to client #8 "It isn't a Hamburger without a Bun." GHS #3 indicated to client #8 the menu called for Hamburger on Bun to be served. Client #8 indicated to GHS #3 she was not eating a Bun and did not want a Bun on her plate. From 5:50pm until 6:05pm, GHS #3 filled clients #1, #2, #4, #5, #6, #7's plates, and asked GHS #1 to fill client #8's plate during dining. GHS #3 stated "I'm not sure what they eat" and did not ask each client before she filled their plates, poured their drinks, and added condiments of mayonnaise and ketchup to the plates. On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated clients #1, #2, #3, #4, #5, #6, #7, and #8's objectives/goals should be implemented when opportunities existed. The DRS indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 should be taught and encouraged to express their wants/needs. The DRS indicated each client should use their skills to assemble their own plate during dining opportunities. The DRS		**information.** **W249 Finding(s):** 1.Onsitemonitoring should be done to ensure ISP's, BSP's, and client objectives areimplemented. The monitoring should be more frequent than weekly. **CorrectiveAction(s):** Onsitemonitoring should be done to ensure ISP's, BSP's, and client objectives areimplemented. 1.TheResidential House Manager and the Residential Lead DSP will review programgoals to ensure they are being completed and implemented, as per the ISP, fourtimes a week. This will be documentedand the Qualified Intellectual Disability Professional (QIDP) will review thedata weekly. If formal programming goals are not being implemented as per theISP or are not being completed the Qualified Intellectual DisabilityProfessional will be retrained all Residential DSP's that work in the home onthe ISP's and program goals. 2.TheResidential House Manager and The Residential Lead DSP have supervisoryresponsibilities in the home seven days a week. They will monitor ResidentialDSP's to ensure that the persons served BSP's are being implemented andfollowed accordingly. If they observe that the BSP's are not being followed andimplemented as they are written the Qualified Intellectual	

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	indicated clients #1, #2, #4, #5, #6, #7, and #8 were verbal and had the skills to fill their own plates, add their own condiments, and pour their own drinks during dining. 2. During observation on 10/13/15 from 3:45pm until 6:05pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home. At 4:00pm, GHS #1 administered medications and on the shelf inside the medication room was a locked box containing locked/secured sharps of knives, forks, can opener, apple coring utensil, razors, and other metal sharp objects. At 4:20pm, GHS #1 retrieved a knife GHS #3 requested. GHS #1 stated the locked sharps were "because of" client #7's behaviors and the facility staff had to "keep sharps locked." At 5:00pm, client #6 was in the kitchen cutting tomatoes with a knife, GHS #4 took the knife from client #6, and finished cutting the tomatoes. At 5:00pm, GHS #4 began to cut lettuce with the knife, GHS #4's personal cell phone in her pocket began to ring, GHS #4 laid the knife down on the counter, walked into the medication room talking on her cell phone. The knife was left unsecured on the counter. At 5:40pm, client #7 walked into the kitchen to wash his hands at the kitchen sink. At 5:50pm, clients #1, #2, #4, #5, #6, #7, and #8 were		DisabilitiesProfessional (QIDP) will be notified and all Residential staff that work in thehome will be retrained on the BSP's.	

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	seated at the dining room table. Two (2) knives laid unsecured on top of the kitchen counter. On 10/14/15 from 9:45am until 11:20am, observation was conducted at the facility owned day services. During the observation period client #7 sat in a classroom with six other clients and one workshop staff and a pair of unsecured metal scissors laid on the table. On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS stated client #7 "required locked sharps" to be secured. On 10/15/15 at 3:10pm, client #1's record was reviewed. Client #1's 12/21/14 ISP (Individual Support Plan) and 2014 Risk Assessment indicated she required 24/7 (twenty-four hours a day/seven days a week) staff supervision. Client #1's ISP indicated objectives to socialize outside of her room, to complete physical therapy exercises, to initiate a chore around the group home, and to speak clearly. On 10/15/15 at 10:59am, client #2's record was reviewed. Client #2's 6/7/2015 ISP, 6/7/2015 BSP (Behavior Support Plan), and 2015 Risk Assessment indicated objectives to			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	2333 WESTDALE CT KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	complete daily chore, to slow rate of bites during meals, to verbally state what she saw in a picture, to not pick her fingernails, to practice spelling first name, to adjust own water temperature, and to identify the letters in her first name. Client #2's plans indicated she required 24/7 (twenty-four hours a day/seven days a week) staff supervision. On 10/15/15 at 1:00pm, client #3's record was reviewed. Client #3's 6/7/15 ISP, 6/7/2015 BSP, and 2015 Risk Assessment indicated objectives to work 15 minutes without losing focus, to complete activities, to clean his bedroom, to complete daily chore, to participate in activities, to cook a side dish, and to wash his hands. Client #3's plans indicated he required 24/7 (twenty-four hours a day/seven days a week) staff supervision. On 10/15/15 at 3:16pm, client #4's record was reviewed. Client #4's 1/21/15 ISP, 1/2015 BSP, and 2014 Risk Assessment indicated he had the skills to choose his food, fill his plate, and pour his drinks. Client #4's plans indicated he required 24/7 (twenty-four hours a day/seven days a week) staff supervision. On 10/19/15 at 10:45am, client #6's record was reviewed. Client #6's 7/25/15			

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	ISP and 7/25/15 BSP indicated objectives to increase pedestrian safety skills and to show ID card with phone number. Client #6's record indicated he needed locked and secured sharps "at all times." Client #6's ISP, BSP, and Risk Assessment indicated he required 24/7 (twenty-four hours a day/seven days a week) staff supervision. On 10/19/15 at 10:30am, client #7's record was reviewed. Client #7's 5/16/15 ISP and 9/25/15 BSP indicated client #7 "required" locked sharps due to prior attempts of hurting other people with knives during waking and sleeping hours. Client #7's plans indicated he required 24/7 (twenty-four hours a day/seven days a week) staff supervision. On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated clients #6 and #7 needed secured locked knives and sharps. The DRS indicated both clients #6 and #7 had a documented behavioral history that sharps should be kept secured and locked "at all times except" when staff were directly supervising the use. 9-3-4(a)			

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W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #4) who had an open wound and a history of MRSA (Methicillin Resistant Staphylococcus Aureus, a skin infection), the facility's nursing staff failed to develop a client specific protocol for client #4's MRSA and open skin area. The facility failed for 1 additional client (client #8) who lived in the group home, to ensure client #8's topical medication was available at the group home on 10/12/15 and 10/13/15. Findings include: 1. During observation on 10/13/15 from 3:45pm until 6:05pm, client #4 walked throughout the group home, no bandage/covering of his lower left leg was observed, and the red shiny skin area extended from below client #4's left knee to above his ankle covering the left lower leg. At 4:25pm, GHS #1 administered client #4's medications, client #4 repeatedly scratched and rubbed his lower left uncovered shiny red skin area with his hands. No hand washing was observed. During the medication administration time client #4's lower left leg was not assessed, treated, and client	W 0331	**Finding(s):** ***1."Thefacility's nursing staff failed to develop a client specific protocol forclient #4's MRSA and open skin area."*** **CorrectiveAction(s):** **Toprovide clients with nursing services in accordance with their needs thefollowing corrective actions will be implemented:** 1.TheResidential Nurse will revise client #4's MRSA risk plan specifying theprotocol for client #4's MRSA and open skin areas. All staff working in thegroup home will be trained on the revised risk plan. Records of training willbe completed following the training and submitted to the Residential Directorfor administrative oversight. (Appendix K) 2.TheResidential House manager will train all staff working in the home onhandwashing/Universal Precautions and Infectious Disease Control. Records oftraining will be completed following the trainings and submitted to theResidential Director for administrative oversight. 3.TheResidential Qualified Intellectual Disabilities Professional (QIDP) will trainall	11/26/2015

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	#4 was not discouraged from scratching/rubbing the area. From 4:28pm until 5:50pm, client #4 scratched and rubbed his open skin area to left lower leg. Client #4 walked into/out of the laundry room, television room, opened/closed doors, went inside/outside, and no handwashing was observed. At 5:50pm, client #4 assisted to set the dining room table with silverware without washing his hands. At 5:50pm, client #4 passed bowls from client to client, handled serving spoons, and fed himself a hamburger on a bun and french fries without washing his hands. From 5:50pm until 6:05pm, client #4 was observed to bend over his chair at the table to reach under his pant hem to scratch and rub his red shiny skin area on his lower left leg then handle food items without washing his hands. On 10/14/15 from 6:35am until 8:15am, client #4 was observed at the group home. At 6:55am, GHS #2 administered client #4's oral medications. At 6:55am, GHS #2 asked client #4 to pull up his pant leg to show his left lower leg. Client #4 pulled up his pant leg. GHS #2 stated client #4's skin area had been open "a couple of months." GHS #2 stated the area on client #4's left lower leg covered the area "three fourths around" and covered "ten inches (10") around left side		staff working in the home on all the clients' informal handwashing goals. Recordsof training will be completed following the training and submitted to theresidential Director for administrative oversight (Appendix L). **Finding(s):** ***b. "Thefacility's nursing staff failed to ensure client #8's topical medication wasavailable at the group home on 10/12/15 and 10/13/15."*** - - **CorrectiveAction(s):** **Toprovide clients with nursing services in accordance with their needs thefollowing corrective actions will be implemented:** 1.TheResidential Nurse will train all staff working in the home on the followingprocedure for reordering medications. On Wednesday's the midnight staff willtake inventory and order anything needed, sign a check list indicating thecompletion of this task, the Residential Lead DSP will review this list onThursday. The Residential Nurse will review this once a week to ensure it hasbeen completed and to ensure additional administrative oversight. Records oftraining will be completed following the training and submitted to theResidential Director for	

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	and middle" of client #4's lower leg. GHS #2 stated client #4's skin area was "red, inflamed, and weepy looking" and indicated she was going to treat and cover the area with a gauze bandage. GHS #2 stated client #4 "picks the area open" on his skin. No sizes/measurements of client #4's open and inflamed skin area were available for review in the MAR (Medication Administration Record). GHS #2 applied a wet wash cloth wiping client #4's open skin area. GHS #2 applied "Mupirocin Ointment USP 2%, apply a small amount to affected area three times a day" to the area, covered the open skin area with a five inch by nine inch (5" x 9") gauze pad, and covered the gauze pad and the remaining red inflamed skin with a roll of gauze covering client #4's entire lower leg. Client #4 left the medication room. No size of the open skin area and no size of the remaining skin inflammation were documented at the time of client #4's medication administration. On 10/15/15 at 3:16pm, client #4's record was reviewed. Client #4's 1/21/15 ISP, 8/2015 BSP, and 2014 Risk Assessment did not indicate the identified behavior of picking his itchy skin. Client #4's record indicated his diagnosis included, but was not limited to: Diabetes Mellitus. Client #4's 1/22/15 "MRSA Plan" and 1/22/15		administrative oversight. (Appendix M)	

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	"Skin Integrity Plan" both indicated client #4 had MRSA and issues from client #4 "picking" his skin. Client #4's "MRSA Plan" indicated "Signs and Symptoms may include: Small red bumps that resemble pimples, spider bites or boils or a rash, fever, wound that won't heal, a general ill feeling, headache. Implementation...(staff) will administer medications as prescribed by the physician and document properly on the MAR...will encourage [client #4] not to pick at his skin and to maintain proper hygiene...will document any cuts, open sores, rashes, small bumps on the Body Integrity Form and use First Aid techniques to treat...." Client #4's MRSA Plan and Skin Integrity Plan did not have a client specific protocol for what safeguards and treatments staff were to implement regarding client #4's skin problems once an open inflamed area was identified. On 10/16/15 at 1:30pm, the DRS (Director of Residential Services) provided multiple sheets of undated "Medication Information" for client #4. An undated "Medication Information" sheet indicated client #4 "has been picking at his left lower leg. His left lower leg now has an open area that is warm to the touch and reddened. There is also green drainage...[Staff] notified on			

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	call of [client #4's] leg. The doctor on call for his family physician prescribed an antibiotic to be given for 10 days. In addition to administering the antibiotic for 10 days...will also: cleanse left lower leg three times daily with soap and water. Then apply Bacitracin and a dressing three times daily. Check left lower leg dressing three times daily to ensure the area is not soiled. If the area is soiled then...cleanse with soap and water and apply bacitracin and a new dressing..." Staff training for the undated Medication Information was completed on 8/16/15 and 4/17/15. Client #4's "Medication Information" was not part of his record, was not incorporated into his medical protocols/plans, and was not available at the group home for staff to refer. Client #4's 10/2015 MAR did not have the undated Medication Information incorporated into client #4's MAR. On 10/15/15 at 9:25am, an interview was conducted with the agency RN. The RN indicated client #4's plans did not have client specific nursing protocols related to his MRSA and recurrent skin issues. The RN indicated client #4 picked his skin when it itched. The RN stated client #4's skin was "red, bloody, and covered" client #4's left lower leg. The RN stated according to client #4's "Body Integrity Form" he had three (3) areas "open" each			

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	"about two inches" from client #4's SIB (Self Injurious Behavior). The RN stated client #4 saw his doctor on 10/12/15 and "if the areas were not healed in 10 days, [client #4] will be referred to the wound clinic." The RN stated client #4's "MRSA was not active" and client #4 had a "history of MRSA." The RN stated "if the area is weepy, it should be covered" with a dressing. On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated no further information was available for review. 2. On 10/13/15 at 4:10pm, GHS (Group Home Staff) #1 asked client #8 into the medication room. GHS #1 administered client #8's oral medications and one topical cream "Fluocinonide 0.05% cream, apply to fingers three times a day" for itchy red skin. GHS #1 indicated client #8's "Triple Antibiotic Cream, apply to fingers three times a day (for red and inflamed skin)...(at) 8:00am, 4:00pm, (and) 8:00pm" was not available for administration. At 5:15pm, the agency RN (Registered Nurse) was present in the group home living room. The RN indicated the facility followed Core A/Core B medication administration training for medication administration.			

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	The RN stated "meds (medications) are refilled by the pharmacy" on a monthly cycle. The RN stated if medications were not available in the group home for administration, the nurse should be notified by the facility staff, and "No" she was not contacted regarding client #8's Triple Antibiotic cream medication not being available. The RN stated "the client should not go without her medications." At 4:20pm, client #8's 10/2015 MAR (Medication Administration Record) and 8/2015 Physician's Order both indicated "Triple Antibiotic Cream, apply to hands and fingers three times a day" for inflamed and red skin. Client #8's 10/2015 MAR indicated client #8 did not receive the medication on 10/12/15 at 4:00pm, 10/12/15 at 8:00pm, 10/13/15 at 8:00am, and 10/13/15 at 4:00pm. On 10/16/15 at 2:45pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated client #8's medication should have been refilled by the pharmacy. The DRS indicated the facility staff had not notified the agency nurse that client #8 was out of her prescribed Triple Antibiotic Cream. The DRS indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for			

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	medication administration. On 10/15/15 at 1:00pm, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be available. 9-3-6(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, for 1 of 5 medications administered (for client #4) during the evening medication administration, the facility failed to administer medication without error for client #4. Findings include: On 10/13/15 from 3:45pm until 4:25pm, client #4 was not observed to eat food at the group home. At 4:25pm, GHS (Group Home Staff) #1 selected client #4's "Janumet 50-1000, take one tablet by mouth twice a day with meals" for NIDDM (Non Insulin Dependent	W 0369	**CorrectiveAction(s):** **Toensure the system for drug administration, including those thatself-administer, are administered without error, the following correctiveactions will be implemented:** 1.TheResidential Nurse will re-train all staff that work in the home on Bona Vista'sMedication Administration Policy and then complete quarterly retraining on BonaVista's medication administration policy with all staff that work in the home.Records of training will be completed following the training and submitted tothe Residential Director for Administrative oversight (Appendix N).	11/26/2015

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	Diabetes Mellitus) and administered the medication to client #4. No food was provided. At 6:02pm, client #4 sat down at the dining room table and consumed his supper meal. On 10/15/15 at 3:16pm, client #4's 10/2015 MAR (Medication Administration Record) and 8/31/2015 "Physician's Order" both indicated "Janumet 50-1000, take one tablet by mouth twice a day with meals" for NIDDM (Non Insulin Dependent Diabetes Mellitus). On 10/15/15 at 1:50pm, an interview with the agency Licensed Practical Nurse (LPN) was conducted. The LPN indicated staff should ensure client #4's physician's orders were followed to administer client #4's medication with the meal. The LPN indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration. The LPN indicated staff did not follow physician's orders. On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated client #4's medications should be administered according to physician's		2.TheResidential Director of Operations, Residential Director of Quality Assuranceand Social Services, and the Residential QIDP will review all incident reports ona daily basis. If there is 2 or more medication errors in a one week period oftime, the team will meet to discuss interventions for assistance in the home. 3.TheResidential Nurse will train all staff working in the home on the MAR,following physician orders, and special instructions of drug administrationsthat are prescribed by the physician(example taking medications with food…) Records of training will be completedfollowing the training and submitted to the Residential Director for administrativeoversight (Appendix O).	

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	orders. The DRS indicated the facility followed Core A/Core B Medication Administration Training. On 10/15/15 at 1:00pm, a review was conducted of the facility's 4/2011 "Medication Administration Handbook" which both indicated each client's physician orders should be followed. On 10/15/15 at 1:00pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be administered according to physician's orders. 9-3-6(a)			
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8), the facility failed to ensure medication storage closet and medications were kept secured for clients #1, #2, #3, #4, #5, #6, #7, and #8's medication.	W 0382	**CorrectiveAction(s):** **Toensure all drugs and biologicals are locked, in a secured container, exceptwhen being prepared for administration, the following corrective actions willbe implemented:** 1.TheResidential Nurse will re-train all staff working in the	11/26/2015

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	Findings include: On 10/14/15 from 6:55am until 7:10am, GHS (Group Home Staff) #2 requested client #4 to come to the medication room. At 6:55am, GHS #2 unlocked the medication cabinet, removed client #4's medication bin from the cabinet, and set the medication bin on top of the desk in front of client #4. From 6:55am until 7:10am, client #4 sat at the desk with his medication at eye level in front of him. From 6:55am until 7:10am, GHS #2 left the medication room twice without locking client #4's medications laying on the desk, locking the medication cabinet, and without the medication being within staff's eye sight. One time GHS #2 left the room to retrieve gloves and the second time was to retrieve a wet wash cloth. At 7:10am, GHS #2 relocked/secured client #4's medications from on top of the desk into the medication cabinet and locked the cabinet. At 7:25am, GHS #2 indicated she had left the room twice during client #4's medication administration and had failed to secure his medications and the medication cabinet. On 10/15/15 at 1:50pm, an interview with the agency Licensed Practical Nurse (LPN) was conducted. The LPN indicated staff should ensure medications		group home on BonaVista's Medication Administration Policy. Additionally the Residential Nursewill conduct quarterly retraining on Bona Vista's medication administration policywith all staff working in the home.(Appendix N)	

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	should be secured when not in the eye sight of the facility staff. The LPN indicated the facility followed the Core A/Core B training for medication administration. On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated the facility followed Core A/Core B Medication Administration Training for medication security. On 10/15/15 at 1:00pm, a review was conducted of the facility's 4/2011 "Medication Administration Handbook" which both indicated each client's physician orders should be followed. On 10/15/15 at 1:00pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" indicated the medication cabinet and medications should be kept secured by the facility staff. 9-3-6(a)			
W 0391 Bldg. 00	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug			

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	15G496	A. BUILDING 00 B. WING	10/27/2015

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	containers with worn, illegible, or missing labels. Based on observation, record review, and interview, for 1 of 5 medications (client #8) who had medications administered during the evening medication administration, the facility failed to remove from use the medication containers without labels and/or illegible labels from the supply on 10/13/15. Findings include: On 10/13/15 at 4:10pm, GHS (Group Home Staff) #1 selected client #8's medication "Fluocinonide 0.05% cream, apply to fingers three times a day" for itchy red skin. GHS #1 applied the cream with client #8 on her fingers to her right and left hands. At 4:10pm, GHS #1 stated the medication label was "worn and missing" on the box and tube could not be read for client #8's name, medication name, dose, and instructions for the medication's use. GHS #1 capped the medication and replaced the box back into client #8's medication supply. At 5:15pm, the agency RN (Registered Nurse) was present in the group home living room. The RN indicated the facility followed Core A/Core B medication administration training for medication administration. The RN stated "meds (medications) should have a	W 0391	**CorrectiveAction(s):** **Toensure that all medications do not have worn, illegible, or missing labels.** 1.TheResidential Nurse will retrain all staff working in the home on the procedurefor recording medications and completing the checklist for medications. OnWednesday's, the midnight staff will ensure that all medications are labeled correctlyas per Bona Vista's Medication Policy and per physician orders, sign a checklist indicating completion of this task, the Residential Lead DSP will reviewthis list on Thursdays. The Residential Nurse will review this on a monthly toensure it has been completed and to ensure additional administrative oversight.Records of training will be completed following the training and submitted tothe Residential Director for administrative oversight (Appendix M)	11/26/2015

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	pharmacy label" which could be read including: the clients' name, name of the medication, dosage, and directions for the medication's use. At 4:20pm, client #8's 10/2015 MAR (Medication Administration Record) and 8/2015 Physician's Order both indicated "Fluocinonide 0.05% cream, apply to fingers three times a day" for itchy red skin. On 10/16/15 at 2:45pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated client #8's medication should have a pharmacy label on the medication that was not worn and client #8's medication was not removed from use. The DRS indicated the pharmacy label should include the client name and directions for the medication use. The DRS indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration. On 10/15/15 at 1:00pm, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled.			

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	9-3-6(a)			
W 0413 Bldg. 00	483.470(b)(1)(iv) CLIENT BEDROOMS Bedrooms must measure at least 80 square feet in single client bedrooms. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #3), the facility failed to ensure client #3's single bedroom measured at least 80 square feet. Findings include: During observations on 10/13/15 from 3:45pm until 6:05pm and on 10/14/15 from 6:35am until 8:15am, client #3 was observed to be a tall muscular client and in a single bedroom. On 10/13/15 at 4:40pm, client #3 stated his bedroom was "small." Client #3 stated his room was "about a six feet by nine feet." At 5:00pm, client #3 stated he was "6' 7" (six feet seven inches)" tall. Client #3 stated his bedroom was "sometimes a little too little" but he liked having a single bedroom. On 10/15/15 at 10:00am, an interview with the DRS (Director of Residential Services) was conducted. The DRS indicated the facility's maintenance person had measured client #3's single	W 0413	**CorrectiveAction(s):** **Toensure client #3's bedroom measures at least 80 square feet for a single clientbedroom, the following corrective actions will be implemented:** 1.Asingle occupancy bedroom measuring 80 square feet for client #3 will be addedto the group home.	11/26/2015

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	bedroom and stated the bedroom was "72 (seventy-two) square feet." The DRS stated client #3 and #7's shared bedroom was "split" in half to provide clients #3 and #7 their own individual single bedrooms by the maintenance person within the past "7-15 months." The DRS indicated client #3's single bedroom was not 80 square feet of living area. On 10/14/15 at 11:40am and on 10/15/15 at 10:00am, records for the bedroom measurements were requested and none were available for review. 9-3-7(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 1 of 3 sampled clients (client #4) with adaptive equipment, facility failed to have client #4's hearing aid available and to have available and encourage client #4 to wear his prescribed eye glasses when opportunities existed.	W 0436	**Correctiveaction(s):** **Toensure that the facility furnishes, maintain in good repair, and teach clientsto use and to make informed choices about the use of dentures, eyeglasses,hearing and other communications aids, braces, and other devices identified bythe interdisciplinary team as needed by the client, the**	11/26/2015

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	Findings include: During observations on 10/13/15 from 3:45pm until 6:05pm and on 10/14/15 from 6:35am until 8:15am, client #4 was at the group home did not wear his prescribed hearing aid and did not wear his prescribed eye glasses. On 10/15/15 at 3:16pm, client #4's record was reviewed. Client #4's 1/21/15 ISP (Individual Support Plan), 1/2015 BSP (Behavior Support Plan), and 2014 Risk Assessment indicated he wore prescribed eye glasses and a right ear prescribed hearing aid. Client #4's ISP indicated an objective for client #4 to wear his right ear hearing aid and his prescribed eye glasses. Client #4's 12/23/14 hearing assessment and 4/21/15 History and Physical both indicated he wore a right ear prescribed hearing aid. Client #4's 1/6/15 visual assessment indicated client #4 wore prescribed eye glasses. On 10/16/15 at 2:45pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated client #4 wore a hearing aid and prescribed eye glasses. The DRS indicated she would need to follow up with staff to determine the status of client #4's right hearing and prescribed eye glasses. The DRS indicated no further		**following correctiveactions will be implemented."** 1.TheResidential Nurse will ensure that client #4's hearing aid is workingappropriately and available for use and client #4's prescription eye glassesare available for use. 2.TheResidential House Manager will train all staff working in the home on client#4's vision risk plan, hearing impairment risk plan, and goals for all staffthat work in the home. Records of training will be completed following thetraining and submitted to the Residential Director for administrative oversight(Appendix P). -	

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	information was available for review. 9-3-7(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #4), the facility failed to implement and teach sanitary methods when opportunities existed for client #4. Findings include: During observation on 10/13/15 from 3:45pm until 6:05pm, client #4 walked throughout the group home, no bandage/covering of his lower left leg was observed, and the red shiny skin area extended from below client #4's left knee to above his ankle covering the left lower leg. At 4:25pm, GHS #1 administered client #4's medications, client #4 repeatedly scratched and rubbed his lower left uncovered shiny red skin area with his hands. No hand washing was observed. During the medication administration time client #4 was not discouraged from scratching/rubbing the area. From 4:28pm until 5:50pm, client #4 scratched and rubbed his open skin	W 0455	**CorrectiveAction(s):** **Toensure there is an active program for the prevention, control, andinvestigation of infection and communicable diseases.** 1.TheResidential House manager will train all staff working in the home onhandwashing/Universal Precautions and Infectious Disease Control. Records oftraining will be completed following the trainings and submitted to theResidential Director for administrative oversight. 2.TheResidential Qualified Intellectual Disabilities Professional (QIDP) will trainall staff that work in the home on all the clients' informal handwashing goals.Records of training will be completed following the training and submitted tothe residential Director for administrative oversight (Appendix J).	11/26/2015

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	area to left lower leg. Client #4 walked into/out of the laundry room, television room, opened/closed doors, went inside/outside, and no handwashing was observed. At 5:50pm, client #4 assisted to set the dining room table with silverware without washing his hands. At 5:50pm, client #4 passed bowls from client to client, handled serving spoons, and fed himself with his hands a hamburger on a bun and french fries without washing his hands. From 5:50pm until 6:05pm, client #4 was observed to bend over his chair at the table to reach under his pant hem to scratch and rub his red shiny skin area on his lower left leg then handle food items without washing his hands. On 10/14/15 from 6:35am until 8:15am, client #4 was observed at the group home. At 6:55am, GHS #2 asked client #4 to pull up his pant leg to show his left lower leg. Client #4 pulled up his pant leg. GHS #2 stated client #4's skin area had been open "a couple of months." GHS #2 stated the area on client #4's left lower leg covered the area "three fourths around" and "ten inches (10") around left side and middle" of client #4's lower leg. GHS #2 stated client #4's skin area was "red, inflamed, and weepy looking" and indicated she was going to treat and cover the area with a gauze bandage. GHS #2			

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	stated client #4 "picks the area open" on his skin. GHS #2 applied "Mupirocin Ointment USP 2%, apply a small amount to affected area three times a day" to the area, covered the open skin area with a five inch by nine inch (5" x 9") gauze pad, and covered the gauze pad and the remaining red inflamed skin with a roll of gauze covering client #4's entire lower leg. Client #4 left the medication room. On 10/15/15 at 3:16pm, client #4's record was reviewed. Client #4's 1/21/15 ISP (Individual Support Plan), 8/2015 BSP (Behavior Support Plan), and 2014 Risk Assessment did not indicate the identified behavior of picking his itchy skin. Client #4's 1/22/15 "MRSA (Methicillin Resistant Staphylococcus Aureus, a skin infection) Plan" and 1/22/15 "Skin Integrity Plan" both indicated client #4 had MRSA and issues from client #4 "picking" his skin. Client #4's "MRSA Plan" indicated "Signs and Symptoms may include: Small red bumps that resemble pimples, spider bites or boils or a rash, fever, wound that won't heal, a general ill feeling, headache. Implementation...(staff) will encourage [client #4] not to pick at his skin and to maintain proper hygiene....." On 10/16/15 at 1:30pm, the DRS (Director of Residential Services)			

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	provided multiple sheets of undated "Medication Information" for client #4. An undated "Medication Information" sheet indicated client #4 "has been picking at his left lower leg. His left lower leg now has an open area that is warm to the touch and reddened. There is also green drainage...[Staff] notified on call of [client #4's] leg. The doctor on call for his family physician prescribed an antibiotic to be given for 10 days. In addition to administering the antibiotic for 10 days...will also: cleanse left lower leg three times daily with soap and water..." On 10/15/15 at 9:25am, an interview was conducted with the agency RN. The RN indicated client #4 should have been taught and encouraged to wash his hands after touching his open skin areas and before dining. The RN indicated client #4 picked his skin when it itched. The RN stated client #4's skin was "red, bloody, and covered" on client #4's left lower leg. The RN stated according to client #4's "Body Integrity Form" he had three (3) areas "open" each "about two inches" from SIB (Self Injurious Behavior). The RN indicated client #4 saw his doctor on 10/12/15 and "if the areas were not healed in 10 days, [client #4] will be referred to the wound clinic." The RN stated client #4's "MRSA was			

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	not active" and client #4 had a "history of MRSA." The RN stated "if the area is weepy. It should be covered" with a dressing. On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated no further information was available for review. On 10/16/15 at 1:30pm, the undated Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions" included washing hands before medication administration, before eating, and after using the restroom. 9-3-7(a)			